

## 6239 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9, Film G199 7-9-56 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Baughness</u> Middle <u>H</u> Last		4. DATE OF DEATH <u>June 18</u> Month <u>18</u> Day <u>19</u> Year <u>56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 5, 1881</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Subsidiary M.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Baughness</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Baughness</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-14-9887</u>	
17. INFORMANT <u>Mrs. Baughness</u>		Address <u>Conowingo, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C. Palmer</u>		DATE SIGNED <u>6/18/56</u>	
EXAMINER'S NAME (Type) <u>Gerald C. Palmer - MD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
<u>Pe/Air - MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify)	22b. DATE THEREOF <u>24/18/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cap Green</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Co - MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Bailey</u>		24a. REG'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>W. S. Bailey</u>	
ADDRESS <u>Darlington</u>		DATE <u>Jun 20, 1956</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. Includes checkboxes for various conditions and a large area for handwritten notes.

BUREAU T. H.

JUL 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06211

6240

## CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Connecticut</u> b. COUNTY <u>— 45x-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rural.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheshire</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Conv. Home.</u>		d. STREET ADDRESS <u>#148 Main Street.</u>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Hedge</u> Last <u>Bassett.</u>		4. DATE OF DEATH Month <u>6</u> Day <u>20</u> Year <u>1956.</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 24 1869</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>8</u> Hours <u>8</u> Min. <u>8</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>	
11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Edward B Whiting</u>		14. MOTHER'S MAIDEN NAME <u>Alice Hedge.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Dr. Col. Wm Bassett, Quarters #54 A.P.P. ind.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerotic C-V Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 18, 1956</u> , to <u>June 20, 1956</u> , that I last saw the deceased alive on <u>June 18, 1956</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Josiah A. Hunt</u> M.D.		ADDRESS (Street, city or town, state) <u>Delta, Pa.</u>	
PHYSICIAN'S NAME (Type) <u>Josiah A. Hunt, M.D.</u>		DATE SIGNED <u>6/21/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal.</u>		22b. DATE THEREOF <u>6/21/56</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>New Bedford, Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Farringham</u> ADDRESS <u>Abertown Md.</u>		24a. REC'D BY REGISTRAR <u>June 21, 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mellie G Perry</u>	

CERTIFICATE OF DEATH

1910

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6219

## CERTIFICATE OF DEATH

Reg. Dist. No.

06212

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			
c. LENGTH OF STAY IN 1b <u>4 days</u>				d. STREET ADDRESS <u>Box 377A</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Baby Boy Bebbler</u>				4. DATE OF DEATH <u>June 13 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 9, 1954</u>	
9. AGE (In years lost birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Robert Hale Bebbler</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Caldwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>0</u>		17. INFORMANT <u>Robert H. Bebbler</u>		Address <u>Bel Air MD R.R.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>763.5</u> <u>Bronchopneumonia (Hemorrhagic)</u> DUE TO (b) <u>14 hrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>14 hrs</u> DUE TO (c) <u>14 hrs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 9, 1956</u> , to <u>June 13, 1956</u> , that I last saw the deceased alive on <u>June 12, 1956</u> , and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. J. Hatem</u> M.D. <u>17 W. Phila. Blvd.</u>				DATE SIGNED <u>6/13/56</u>			
PHYSICIAN'S NAME (Type) <u>F. J. Hatem</u>				ADDRESS (Street, city or town, state) <u>Aberdeen MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 15, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harlington Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>				ADDRESS <u>Harlington</u>		24a. REC'D BY REGISTRAR <u>G. L. Lewis</u>	
24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>				DATE <u>June 14, 1956</u>		24c. REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be completed and filed far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John A. Smith</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1910</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Engineer</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>Aug 10 1935</i>	
9. NAME OF SPOUSE <i>John A. Smith</i>		10. DATE OF DEATH <i>Jun 18 1956</i>	
11. PLACE OF DEATH <i>Home</i>		12. CAUSE OF DEATH <i>Heart Disease</i>	
13. MEDICAL HISTORY <i>None</i>		14. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
15. SIGNATURE OF DECEASED <i>John A. Smith</i>		16. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
17. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		18. SIGNATURE OF CLERK <i>John A. Smith</i>	

BUREAU V. S.

JUN 19 1956

RECEIVED

1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 4, 8, Film G199 7-9-56 et

06213

6241

## CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Harford</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Harford</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Edgewood</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>ARTHUR REMI BELL</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>June 27, 1956</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>single</b>	8. DATE OF BIRTH <b>May 31, 1956</b>	9. AGE last birthday <b>26</b> yrs.	IF UNDER 1 YEAR Months <b>26</b>		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Aberdeen, Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>Remi P. Bell</b>				14. MOTHER'S MAIDEN NAME <b>Geraldine Kinney</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go, or unk.) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT & ADDRESS <b>Remi P. Bell, Edgewood Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
228X IMMEDIATE CAUSE (A) <b>PNEUMONIA (TERMINAL)</b>						<b>1 MONTH</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>MULTIPLE CONGENITAL HEMANGIOMATA,</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>PROBABLY MALIGNANT IN NATURE</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>6/25, 1956</b> , to <b>6/27, 1956</b> , that I last saw the deceased alive on <b>6/25, 1956</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Edward R. McHenry Jr.</b>				ADDRESS (Street, city, town, state) <b>Box 95, Edgewood, Md.</b>		DATE SIGNED <b>6/27/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>June 29, 1956</b>		NAME OF CEMETERY OR CREMATORY <b>St. Francis</b>		LOCATION (City, town, or county) (State) <b>Abingdon, Harford, Md.</b>	
24. REC'D BY REGISTRAR <b>June 29, 1956</b>		REGISTRAR'S SIGNATURE <b>Norma G. Moore</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Edward R. McHenry Jr.</b>		ADDRESS	

2050302XV7

# CERTIFICATE OF DEATH

1956

PLACE OF BIRTH [Faint text]		SEX [Faint text]	
DATE OF BIRTH [Faint text]		RACE [Faint text]	
PLACE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
NAME OF DECEASED [Faint text]		NAME OF PHYSICIAN [Faint text]	
ADDRESS OF DECEASED [Faint text]		ADDRESS OF PHYSICIAN [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
MEDICAL HISTORY [Faint text]		PATHOLOGICAL FINDINGS [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF DECEASED [Faint text]	

BUREAU V. 3

JUL 2 1956

RECEIVED



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly must be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6242

## CERTIFICATE OF DEATH

06214

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air Rural</u>		LENGTH OF STAY (If this place) <u>14 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>RD 1</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>HARRY</u> (Middle) <u>Payne</u> (Last) <u>Brown</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 29, 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov 5 - 1891</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Curtis Mag. Circulation</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ellenville NY</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Wm Harry Brown</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Payne</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>163-10-8786</u>		17. INFORMANT & ADDRESS <u>MR. MAGLISH BROWN Bel Air MD RD 1</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
163X IMMEDIATE CAUSE (A) <u>Cancer of lung.</u>						Approx. 1 yr.	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>August 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Cancer of lung</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 28, 1956</u> , to <u>June 29, 1956</u> , that I last saw the deceased alive on <u>June 29, 1956</u> , and that death occurred at <u>11:50 a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert Barthel</u> M.D.				ADDRESS (Street, city, town, state) <u>Forest Hill, Maryland</u>		DATE SIGNED <u>6-29-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>July 1-56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>		LOCATION (City, town, or county) (State) <u>Fountain Green Harford MD</u>	
24. REC'D BY REGISTRAR DATE <u>6-30-56</u>		REGISTRAR'S SIGNATURE <u>Willa Lowwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. Lister Bel Air Md</u>			

# CERTIFICATE OF DEATH

Form 100-110

1. (NAME) (SURNAME) (FIRST) (MIDDLE) (LAST)

2. PLACE OF BIRTH

3. SEX

4. DATE OF BIRTH

5. RACE

6. OCCUPATION

7. CAUSE OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. NAME OF PHYSICIAN

12. NAME OF HOSPITAL

13. NAME OF FUNERAL HOME

BUREAU V. 1

JUL 3 1956

RECEIVED

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF REGISTRAR

6243

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06215

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HARVRE DE GRACE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HARVRE DE GRACE</b>	
c. LENGTH OF STAY IN 1b <b>9 yrs.</b>		d. STREET ADDRESS <b>POST ROAD</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>POST ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>MARY</b> First Middle Last <b>BROWN</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>3</b> Year <b>1956</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>BLACK</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR. 15-1892</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>
11. BIRTHPLACE (State or foreign country) <b>VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	

13. FATHER'S NAME <b>Unknown</b>	14. MOTHER'S MAIDEN NAME <b>Unknown</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>	16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT <b>Wm. S. ANDERSON IV</b>	Address <b>RURAL HARVRE DE GRACE</b>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerosis</b> DUE TO <b>—</b> (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>unknown</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>—</b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>
20f. (City or town) <b>—</b>		(County) <b>—</b> (State) <b>—</b>

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
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ACTUAL SIGNATURE <b>Philip W. Heuman</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <b>June 4, 1956</b>
EXAMINER'S NAME (Type) <b>PHILIP W. HEUMAN</b>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6-5-1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. James</b>	22d. LOCATION (City, town, or county) <b>Harvde Grace</b>	(State) <b>MD.</b>
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23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Madison Mitchell</b>	ADDRESS <b>Harvde Grace, Md.</b>	24a. REC'D BY REGISTRAR <b>June 5-1956</b>	24b. REGISTRAR'S SIGNATURE <b>G. L. Lewis m.d.</b>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
JUN 8 1956  
BUREAU V. S.

6244

## CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Hayford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cassin Run</i>		c. LENGTH OF STAY IN 1b <i>9 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <i>Albert</i> Middle <i>Casimir</i> Last		4. DATE OF DEATH Month <i>6</i> Day <i>20</i> Year <i>1956</i>	
5. SEX <i>White Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/8/1879</i>
9. AGE (In years last birthday) <i>77</i> yrs.		IF UNDER 1 YEAR: Months <i>7</i> Days <i>7</i> Hours <i>7</i> Min. <i>7</i>	
10a. USUAL OCCUPATION (Type and kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter/Plumber</i>	
11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>Italy</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Samuel P. Cassino</i> Address <i>Town Road Cassin Run Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO <i>Arteriosclerotic C.V. Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>4221</i> (b) <i>Arteriosclerotic C.V. Disease</i> DUE TO <i>Arteriosclerotic C.V. Disease</i> (c) <i>Arteriosclerotic C.V. Disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>8 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept 4</i> , 19 <i>56</i> , to <i>June 20</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>June 20</i> , 19 <i>56</i> , and that death occurred at <i>10:20 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Ralph Horky</i> M.D.		DATE SIGNED <i>June 21</i>	
PHYSICIAN'S NAME (Type) <i>J. Ralph Horky MD</i>		<i>Churchville</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>6/23/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Edin</i>	22d. LOCATION (City, town, or county) (State) <i>Harold Chase, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington + Son</i>		ADDRESS <i>Harold Chase, Md</i>	
24a. REC'D BY REGISTRAR <i>June 22-56</i>		24b. REGISTRAR'S SIGNATURE <i>Nellie P. Perry</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED  
JUN 25 1956  
BUREAU K. J.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06217

Reg. Dist. No. 180

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Joppa</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Joppa</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>Madeleine Susan Conklin</b>		4. DATE OF DEATH <b>JUNE 4 1956</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 11, 1950</b>
9. AGE (In years last birthday) <b>5</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Aberdeen, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Donald J. Conklin</b>		14. MOTHER'S MAIDEN NAME <b>Yvette Brion</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Donald J. Conklin, Joppa Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning due to aspiration, instant</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>water and vomitus.</b> DUE TO (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell in pond and didn't come up.</b>	
20c. TIME OF INJURY Month, Day, Year <b>June 4 1956</b> Hour <b>11:30</b> o. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b> 20f. (City or town) <b>Pine Rd, Joppa, Harford, Md</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Philip W. Heuman</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Philip W. Heuman</b>		DATE SIGNED <b>June 4, 1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 6, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>	22d. LOCATION (City, town, county) (State) <b>Bel Air Harford Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. McComas &amp; Son</b>		24a. REC'D BY REGISTRAR <b>June 7, 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Norma B. Moore</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to cremation, or removal.

Harford

Maryland

Harford

Topps

2 yrs

ps

MARLENE SUSAN CONKLIN  
white

Aberdeen, Maryland

none

none

Yvette Br...

mailed J. Conklin

Donald J. Con...

none

*Draining the  
water from*

BUREAU V. S.

JUN 11 1956

RECEIVED

Full

30 - June 26

*July*

Prt.

Bart

6246  
CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWOOD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWOOD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>OAK STREET</u>				d. STREET ADDRESS <u>OAK STREET</u>			
3. NAME OF DECEASED (Type or print) First <u>MICHAEL</u> Middle <u>JOSEPH</u> Last <u>CRONIN</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1893</u> <u>JANUARY 5, 1893</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Munitions Inspector</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
13. FATHER'S NAME <u>MICHAEL CRONIN</u>				14. MOTHER'S MAIDEN NAME <u>Teresa Ryan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1918-1943</u>				16. SOCIAL SECURITY NO. <u>151-20-5071</u>		17. INFORMANT <u>Son - George M. CRONIN</u> Address <u>EDGEWOOD, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA of the Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 15</u> , 19 <u>56</u> , to <u>June 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 15</u> , 19 <u>56</u> , and that death occurred at <u>1:15 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Paul S. Stonesifer Jr.</u> M.D. <u>115 FULFORD AVE., BEL AIR, MD</u>							
PHYSICIAN'S NAME (Type) <u>PAUL S. STONESIFER JR.</u>				June 15, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/19/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Post Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Army Chemical Center, Harford, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McComas &amp; Son</u> ADDRESS <u>Abingdon, Md.</u>				24a. REC'D BY REGISTRAR <u>June 20, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Norma E. Moore</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH COUNTY STATE		MARITAL STATUS SINGLE MARRIED WIDOWED DIVORCED	
DATE OF BIRTH MONTH DAY YEAR		DATE OF DEATH MONTH DAY YEAR	
PLACE OF DEATH COUNTY STATE		CAUSE OF DEATH (List in order of sequence) 1. 2. 3.	
SEX MALE FEMALE		RACE WHITE NEGRO OTHER	
OCCUPATION (If deceased was a professional, list the profession) (If deceased was a laborer, list the occupation) (If deceased was a homemaker, list the occupation) (If deceased was a student, list the school) (If deceased was a retired person, list the former occupation) (If deceased was a volunteer, list the organization) (If deceased was a member of a religious organization, list the organization) (If deceased was a member of a fraternal organization, list the organization) (If deceased was a member of a social organization, list the organization) (If deceased was a member of a political organization, list the organization) (If deceased was a member of a labor union, list the union) (If deceased was a member of a veterans organization, list the organization) (If deceased was a member of a military organization, list the organization) (If deceased was a member of a police organization, list the organization) (If deceased was a member of a fire organization, list the organization) (If deceased was a member of a law enforcement organization, list the organization) (If deceased was a member of a judicial organization, list the organization) (If deceased was a member of a legislative organization, list the organization) (If deceased was a member of an executive organization, list the organization) (If deceased was a member of a cabinet organization, list the organization) (If deceased was a member of a state organization, list the organization) (If deceased was a member of a federal organization, list the organization) (If deceased was a member of an international organization, list the organization) (If deceased was a member of a global organization, list the organization) (If deceased was a member of a world organization, list the organization) (If deceased was a member of a universal organization, list the organization) (If deceased was a member of a cosmic organization, list the organization) (If deceased was a member of a universal organization, list the organization) (If deceased was a member of a world organization, list the organization) (If deceased was a member of a global organization, list the organization) (If deceased was a member of a universal organization, list the organization) (If deceased was a member of a cosmic organization, list the organization)		PLACE OF DEATH COUNTY STATE	
SIGNATURE OF DECEASED (If deceased was a minor, list the name of the parent or guardian) (If deceased was a married person, list the name of the spouse) (If deceased was a widowed person, list the name of the deceased) (If deceased was a divorced person, list the name of the deceased) (If deceased was a single person, list the name of the deceased) (If deceased was a student, list the school) (If deceased was a retired person, list the former occupation) (If deceased was a volunteer, list the organization) (If deceased was a member of a religious organization, list the organization) (If deceased was a member of a fraternal organization, list the organization) (If deceased was a member of a social organization, list the organization) (If deceased was a member of a political organization, list the organization) (If deceased was a member of a labor union, list the union) (If deceased was a member of a veterans organization, list the organization) (If deceased was a member of a military organization, list the organization) (If deceased was a member of a police organization, list the organization) (If deceased was a member of a fire organization, list the organization) (If deceased was a member of a law enforcement organization, list the organization) (If deceased was a member of a judicial organization, list the organization) (If deceased was a member of a legislative organization, list the organization) (If deceased was a member of an executive organization, list the organization) (If deceased was a member of a cabinet organization, list the organization) (If deceased was a member of a state organization, list the organization) (If deceased was a member of a federal organization, list the organization) (If deceased was a member of an international organization, list the organization) (If deceased was a member of a global organization, list the organization) (If deceased was a member of a universal organization, list the organization) (If deceased was a member of a cosmic organization, list the organization)		SIGNATURE OF DECEASED (If deceased was a minor, list the name of the parent or guardian) (If deceased was a married person, list the name of the spouse) (If deceased was a widowed person, list the name of the deceased) (If deceased was a divorced person, list the name of the deceased) (If deceased was a single person, list the name of the deceased) (If deceased was a student, list the school) (If deceased was a retired person, list the former occupation) (If deceased was a volunteer, list the organization) (If deceased was a member of a religious organization, list the organization) (If deceased was a member of a fraternal organization, list the organization) (If deceased was a member of a social organization, list the organization) (If deceased was a member of a political organization, list the organization) (If deceased was a member of a labor union, list the union) (If deceased was a member of a veterans organization, list the organization) (If deceased was a member of a military organization, list the organization) (If deceased was a member of a police organization, list the organization) (If deceased was a member of a fire organization, list the organization) (If deceased was a member of a law enforcement organization, list the organization) (If deceased was a member of a judicial organization, list the organization) (If deceased was a member of a legislative organization, list the organization) (If deceased was a member of an executive organization, list the organization) (If deceased was a member of a cabinet organization, list the organization) (If deceased was a member of a state organization, list the organization) (If deceased was a member of a federal organization, list the organization) (If deceased was a member of an international organization, list the organization) (If deceased was a member of a global organization, list the organization) (If deceased was a member of a universal organization, list the organization) (If deceased was a member of a cosmic organization, list the organization)	

2

X

BUREAU V. S.

JUN 22 1956

RECEIVED



**INSTRUCTIONS**

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy must be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06219

6247

# CERTIFICATE OF DEATH

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Harford</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Harlingen</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harlingen</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>Timothy L. Heckmar</u>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>June 19 1956</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>Sept 10 1877</u>
<b>9. AGE last birthday</b> <u>78</u> yrs.		<b>10. IF UNDER 1 YEAR</b> (Months) (Days) (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Household worker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Harford Co, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>	
<b>13. FATHER'S NAME</b> <u>Ervin Heckmar</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Jane C. Morrison</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>No</u>	
<b>17. INFORMANT &amp; ADDRESS</b> <u>Now Alive Berkin</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>18. MEDICAL CERTIFICATION</b>	
<b>IMMEDIATE CAUSE (A)</b> <u>Chronic Myocarditis</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 yr</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Arteriosclerosis</u>		<u>3 yr</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <u>Kidney Condition</u>		<u>3 yr</u>	
<b>19a. DATE OF OPERATION</b> <u>None</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	
<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>		<b>21d. HOW DID INJURY OCCUR?</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)</b> <u>M.</u>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>	
<b>22. I hereby certify that I attended the deceased from <u>3/25</u>, 19<u>56</u>, to <u>6/19</u>, 19<u>56</u>, that I last saw the deceased alive on <u>June 19</u>, 19<u>56</u>, and that death occurred at <u>109</u> M., from the causes and on the date stated above.</b>			
<b>SIGNATURE</b> <u>F. V. Snodgrass</u>		<b>DATE SIGNED</b> <u>6-20-56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>24. NAME OF CEMETERY OR CREMATORY</b> <u>Harlingen Cem.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>June 23 1956</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Harlingen Md.</u>	
<b>24. REGISTRAR'S SIGNATURE</b> <u>C. H. Kirtz</u>		<b>25. ADDRESS</b> <u>Bailey, Harlingen Md.</u>	

BUREAU V. S.

JUL 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06220

6220

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville, Md</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Harford Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rocco</b> Middle <b>Di Marco</b> Last <b>Di Marco</b>		4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 14, 1898</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired TRACK FOREMAN-PRR</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>	
13. FATHER'S NAME <b>deceased - Emilio Di Marco</b>		14. MOTHER'S MAIDEN NAME <b>deceased - Mary Zullo</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>717-07-5490</b>	
17. INFORMANT <b>SON - Albert J. Di Marco - SON</b>		Address <b>Perryville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myo cardial infarction</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> DUE TO <b>Cutaneous cluws</b> (c) <b>Cutaneous cluws</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6/1/56</b> , 19 <b>56</b> , to <b>6/1/56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>6/1/56</b> , 19 <b>56</b> , and that death occurred at <b>8 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Irvin L. Wachsmen</b>		ADDRESS (Street, city or town, state) <b>Havre de Grace</b>	
PHYSICIAN'S NAME (Type) <b>Irvin L. Wachsmen</b>		DATE SIGNED <b>6/1/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/4/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Erin Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Havre de Grace, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Son,</b>		ADDRESS <b>Perryville, Md.</b>	
24a. REC'D BY REGISTRAR <b>June 2-1956</b>		24b. REGISTRAR'S SIGNATURE <b>G. L. Lewis M.D.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V. S.

1956 5

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06221

6248

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Prospect</u>		<u>2 mo</u>		TOWN <u>Prospect Rural</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Etta</u> (Middle) <u>Mary</u> (Last) <u>Dixon</u>				(Month) <u>June</u> (Day) <u>30</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>White</u>	<u>Married</u>	<u>Jan 28, 1897</u>	<u>59</u> yrs.	Months <u>3</u>	Days <u>0</u>	Hours <u>0</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Housewife</u>			<u>—</u>		<u>Taylor Harford, Md</u>		<u>U.S.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George Coe</u>				<u>Malinda Wright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Rush S Dixon</u> <u>Whiteford Md</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
260X IMMEDIATE CAUSE (A) <u>Cerebral Atrophy.</u>							<u>3 years</u>
ANTECEDENT CAUSE(S) DUE TO <u>Vascular degeneration in region of left</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Sylvian Fissure.</u>							
(C) <u>Diabetes Mellitus.</u>							<u>5 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		<u>None.</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County)	(State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 24</u> , 19 <u>55</u> , to <u>June 25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 25</u> , 19 <u>56</u> , and that death occurred at <u>1:15 a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert Barthel</u>				ADDRESS (Street, city, town, state) <u>Forest Hill, Maryland</u>		DATE SIGNED <u>7-2-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>July 24</u>		<u>Belair Mem. Gardens</u>		<u>Belair Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>7-3-56</u>		<u>Purcella Lowwood</u>		<u>Marion E. Kuntz</u>		<u>Sanctiwood Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly must be detached for use as a burial transit permit.

VS AISC 1-55 10M



CERTIFICATE OF DEATH

Decedent's Name: *Harold*  
Age: *2*  
Sex: *Male*  
Race: *White*  
Date of Birth: *1954*  
Place of Birth: *Harford, Md.*

Usual Residence: *Harford, Md.*  
Cause of Death: *Accident*  
Place of Death: *Harford, Md.*  
Date of Death: *1954*  
Signature: *[Signature]*

BUREAU V. 2

JUL 6 1956

RECEIVED

For information of Bureau of Health Statistics

Enclosed for Bureau of Health Statistics

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

06222

Reg. Dist. No. 182

6249

1. PLACE OF DEATH COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>_____</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL BELAIR</u> LENGTH OF STAY (in this place) <u>5 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALTO City</u> 3 Vol-4 J	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>?</u>	
3. NAME OF DECEASED (First) <u>Carrie</u> (Middle) <u>Ford</u> (Last) <u>Ford</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>20</u> (Year) <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>Feb. 8 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME-REPAIR</u>	9. AGE last birthday <u>83</u> yrs. If under 1 year: Months <u>_____</u> Days <u>_____</u> Hours <u>_____</u> Min. <u>_____</u>
13. FATHER'S NAME <u>George Ford</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>_____</u>		14. MOTHER'S MAIDEN NAME <u>Elinor Shay</u>	
16. SOCIAL SECURITY No. <u>_____</u>		17. INFORMANT <u>Stanley S. Ford-Harrod Lane, MD RD.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<p>422.1 Immediate cause (a) <u>Cerebral Thrombosis</u></p> <p>Antecedent cause(s) (b) <u>Arterio-sclerotic C-V Disease</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>_____</u></p>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>_____</u> SUICIDE <u>_____</u> HOMICIDE <u>_____</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>_____</u> INJURY <u>_____</u>	(CITY OR TOWN) <u>_____</u> (COUNTY) <u>_____</u> (STATE) <u>_____</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>_____</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>_____</u>
22. I hereby certify that I attended the deceased from <u>June 15, 1956</u> , to <u>June 20, 1956</u> , that I last saw the deceased alive on <u>June 15, 1956</u> , and that death occurred at <u>4:30 A</u> m., from the causes and on the date stated above.		
SIGNATURE <u>Joseph A. Hunt, MD.</u> ADDRESS <u>Delta On</u>		DATE SIGNED <u>6/20/56</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>JUNE 22 56</u>	NAME OF CEMETERY OR CREMATORY <u>Spaulding Cemo</u>
LOCATION (City, town, or county) <u>Harford Co</u>	(State) <u>MD.</u>	
DATE REC'D BY LOCAL REG. <u>6-23-56</u>	REGISTRAR'S SIGNATURE <u>Purella Bonwood</u>	24. FUNERAL DIRECTOR <u>W. Madison Mitchell</u> ADDRESS <u>Harrod Lane, MD.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 26 1956

BUREAU V. S.

6221

## CERTIFICATE OF DEATH

Reg. Dist. No.

186-

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVRE DE GRACE</b>		c. LENGTH OF STAY IN IB <b>53 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LOY</b> First <b>EMORY</b> Middle <b>GOODRICH</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>19 56</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 6, 1884</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penn R.R.</b>	
11. BIRTHPLACE (State or foreign country) <b>Lansing, Mich.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK GOODRICH</b>		14. MOTHER'S MAIDEN NAME <b>JENNIE MANLEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>UNK</b>		16. SOCIAL SECURITY NO. <b>UNK.</b>	
17. INFORMANT <b>Mrs. IOMA S. GOODRICH</b>		Address <b>721 Warren St</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Embolism</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Occlusion &amp; infarctions</b> DUE TO (c) <b>Chronic myocarditis -</b>			INTERVAL BETWEEN ONSET AND DEATH <b>few minutes</b> <b>1 day -</b> <b>5 years -</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March</b> , 1939, to <b>June 16</b> , 1956, that I last saw the deceased alive on <b>June 16</b> , 1956, and that death occurred at <b>5 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank Wolbert MD</b> M.D.		ADDRESS (Street, city or town, state) <b>Havre de Grace Md</b> DATE SIGNED <b>6/16/56</b>	
PHYSICIAN'S NAME (Type) <b>FRANK WOLBERT MD</b>		<b>Havre de Grace - Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/18/ 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Havre de Grace Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b> ADDRESS <b>Havre de Grace, Md</b>		24a. REC'D BY REGISTRAR <b>June 18-1956</b> 24b. REGISTRAR'S SIGNATURE <b>G. L. Lewis M.D.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of 3 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		MALE		65		JAN 15 1880		BALTIMORE		MARYLAND		UNITED STATES			
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
RETIRED		HEART DISEASE		NATURAL		2 WEEKS		JUN 18 1956		BALTIMORE		MARYLAND		UNITED STATES	
FATHER'S NAME		MOTHER'S NAME		SPOUSE'S NAME		CHILDREN		EDUCATION		RELIGION		RACE		COLOR	
JAMES H. HARRIS		MARY H. HARRIS		JANE H. HARRIS		3		HIGH SCHOOL		METHODIST		WHITE		WHITE	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
JUN 18 1956		BALTIMORE		MARYLAND		UNITED STATES				JUN 18 1956		BALTIMORE		MARYLAND	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF DECEASED	
JAMES H. HARRIS		MARY H. HARRIS		JANE H. HARRIS		JAMES H. HARRIS		MARY H. HARRIS		JANE H. HARRIS		JAMES H. HARRIS		MARY H. HARRIS	

BUREAU V. S.

JUN 19 1956

RECEIVED



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy must be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06224

## 6222 CERTIFICATE OF DEATH

Reg. Dist. No. 185-

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <i>Harford</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Harford</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Harrede Grace</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>FOREST HILL</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Harford Memorial Hospital</i>		STREET ADDRESS (If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Jesse ZERO Goss.</i>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>6-14 1956</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>FEB. 11, 1873</i>
9. AGE last birthday <i>83</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>retired</i>	
11. BIRTHPLACE (State or foreign country) <i>Foxy, Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jack Goss.</i>		14. MOTHER'S MAIDEN NAME <i>Nellie Cox.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS <i>Harford Memorial Hospital</i>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			<b>18. MEDICAL CERTIFICATION</b>
610X IMMEDIATE CAUSE (A) <i>uremia</i>			INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSE(S) DUE TO (B) <i>Benign prostatic hypertrophy</i>			<i>2 yrs.</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>generalized arteriosclerosis</i>			
19a. DATE OF OPERATION <i>none</i>		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>6/5/56</i> to <i>6/14/56</i> , that I last saw the deceased alive on <i>6/13/56</i> , and that death occurred at <i>6:40 P.M.</i> from the causes and on the date stated above. <i>6/16/56</i>			
SIGNATURE <i>Uriford A. Council Jr.</i>		ADDRESS (Street, city, town, state) <i>98 Mt Royal Ave. Balto Md.</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>JUNE 17, 56</i>	
24. REC'D BY REGISTRAR <i>Joseph J. Foster</i>		REGISTRAR'S SIGNATURE <i>Joseph J. Foster</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph J. Foster</i>		ADDRESS <i>Bd Air Md.</i>	

# CERTIFICATE OF DEATH

THIS IS TO CERTIFY

that the following person has died

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

IN MEDICAL CERTIFICATION

STATE OF MARYLAND, COUNTY OF BALTIMORE

BUREAU V. S.

JUN 18 1956

RECEIVED

1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 6223 CERTIFICATE OF DEATH

06225

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARTFORD</u>		STATE <u>MD</u>		COUNTY <u>HARTFORD</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bell Air</u>		LENGTH OF STAY (in this place) <u>6 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bell Air MD</u>			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Rev James Edward Grant DD</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 13 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>July 10-1866</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Portsmouth Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William Grant</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Adams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>MRS MARY HORANT</u> <u>EMERSON ST BELL AIR MD</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
450.0 IMMEDIATE CAUSE (A) <u>CARDIO-RESPIRATORY FAILURE</u>				72 HOURS			
ANTECEDENT CAUSE(S) DUE TO (B) <u>ADVANCED ARTERIO SCLEROSIS</u>				5 YEARS			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>PERNICIOUS ANEMIA</u>				8 YRS			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 <u>47</u> , to <u>13 JUNE 56</u> , that I last saw the deceased alive on <u>13 JUNE 56</u> , and that death occurred at <u>7:53A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J. H. Adwell</u>				DATE SIGNED <u>13 June 56</u>			
M. D. <u>Bell Air, MD</u>				ADDRESS (Street, city, town, state)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JUNE 16/56</u>		NAME OF CEMETERY OR CREMATORY <u>Westbury Funeral Home</u>		LOCATION (City, town, or county) (State) <u>Westbury NY</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Priscilla Lowood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Lister</u>		ADDRESS <u>Bell Air MD</u>	
DATE <u>6-14-56</u>							

# CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is mostly blank with some faint markings.

BUREAU V. S.

JUN 18 1956

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy must be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06226

6224

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Hartford</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Hartford</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Harbor de Grace</i>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Harbor de Grace</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Hartford Memorial Hospital</i>				STREET ADDRESS (If rural give location) <i>719 S. Union Ave</i>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <i>Baby</i>		(Middle) <i>Girl</i>		(Last) <i>Gregg</i>		(Month) (Day) (Year) <i>June 29, 1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>June 28 56</i>	9. AGE last birthday <i>1 day 01 yrs.</i>	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Frank LeRoy Gregg</i>				14. MOTHER'S MAIDEN NAME <i>Pearl Eurith Brown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Mr. Frank Gregg - Harbor de Grace, Md.</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
774X IMMEDIATE CAUSE (A) _____				Prematurity			
ANTECEDENT CAUSE(S) DUE TO _____				Multiple pregnancy (twins)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO _____				Interval between ONSET and DEATH <i>1 day 8 mol.</i>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <i>6-28-56</i> <b>to</b> <i>6-29-56</i> <b>that I last saw the deceased alive on</b> <i>6-29-56</i> <b>and that death occurred at</b> <i>10:25 PM</i> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <i>Walter J. Kohnen, M.D.</i> <b>ADDRESS</b> (Street, city, town, state) <i>Abertown, Md.</i> <b>DATE SIGNED</b> <i>6-30-56</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>7-1-56</i>		NAME OF CEMETERY OR CREMATORY <i>Union Methodist Cem.</i>		LOCATION (City, town, or county) (State) <i>Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>L. Lewis</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Walter J. Kohnen</i>		ADDRESS <i>Harbor de Grace, Md.</i>	
DATE <i>July 1-1956</i>							

Weight  
2-14 1/4



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1956 JUL 3

1. NAME OF DECEASED (Print Name)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF CHURCH OFFICIAL

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BUREAU V. A.

JUL 3 1956

RECEIVED

7-1-56 Bureau of Health Statistics  
State of Maryland

RECEIVED  
BUREAU OF HEALTH STATISTICS  
STATE OF MARYLAND  
BALTIMORE, MD

6250

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH o. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL-DARLINGTON</b>				c. LENGTH OF STAY IN 1b <b>78 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>RURAL-DARLINGTON</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM THOMAS HARKINS</b>				4. DATE OF DEATH Month Day Year <b>JUNE 19, 1956</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 24, 1877</b>		9. AGE (In years last birthday) <b>78</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARM OWNER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AGRI.</b>		11. BIRTHPLACE (State or foreign country) <b>HARFORD CO., MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANKLIN HARKINS</b>				14. MOTHER'S MAIDEN NAME <b>EMMA ROBINSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>_____</b>		17. INFORMANT Address <b>MRS. ETTA W. HARKINS, DARLINGTON, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>241X Asthma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Bronchitis</b> DUE TO (c) <b>4 yr</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 yr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan 19, 1953</b> to <b>June 19, 1956</b> that I last saw the deceased alive on <b>June 18, 1956</b> , and that death occurred at <b>1100</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Darlington Md</b> DATE SIGNED <b>6/21/56</b>							
ACTUAL SIGNATURE <b>F. Snodgrass</b> M.D.				DATE SIGNED <b>6/21/56</b>			
PHYSICIAN'S NAME (Type) <b>F. Snodgrass</b>				ADDRESS <b>Darlington Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-23-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>DARLINGTON</b>		22d. LOCATION (City, town, or county) (State) <b>DARLINGTON, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Harkins</b>				ADDRESS <b>Delta, Pa.</b>		24a. REC'D BY REGISTRAR DATE <b>6-23-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Priscilla Howard</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND—DEPARTMENT OF HEALTH—Baltimore

BUREAU V. 8

JUN 26 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06228

6225

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Harre de Grace</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Port Deposit 07X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hosp</u>				STREET ADDRESS (If rural give location) <u>Box 298</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Berlinde Ann Harris</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>6 13 19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>6-7-56</u>	9. AGE last birthday yrs.	IF UNDER 1 Year Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Harre de Grace, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Rufus Harris</u>				14. MOTHER'S MAIDEN NAME <u>Thelma Yancey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>Mrs. Thelma Y. Harris - Port Deposit</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
754.4 IMMEDIATE CAUSE (A) <u>Acute Cardiac Failure</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Acute Pericarditis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/8</u> , 19 <u>56</u> , to <u>6/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/13</u> , 19 <u>56</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George J. Stancbury</u>				ADDRESS (Street, city, town, state) <u>369 Revolution St. Harre de Grace, Md.</u>			
DATE <u>June 14, 1956</u>				DATE SIGNED <u>6/14/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-15-56</u>		NAME OF CEMETERY OR CREMATORY <u>Jones Memorial Cem.</u>		LOCATION (City, town, or county) (State) <u>Cokebury Cecil Co. Md.</u>	
24. REC'D BY REGISTRAR <u>A. L. Lewis</u>		REGISTRAR'S SIGNATURE <u>A. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Celia J. Bullock</u>		ADDRESS <u>556 Lenoir St. Harre de Grace, Md.</u>	

2071284 XV5

CERTIFICATE OF DEATH

5325

DATE OF DEATH

1956  
JUN 13

TIME OF DEATH

10:00 AM

PLACE OF DEATH

HOME

AGE

65

SEX

MALE

RACE

WHITE

EDUCATION

8

RELIGION

ROMAN CATHOLIC

CAUSE OF DEATH

HEART DISEASE

DATE OF DEATH

JUN 13 1956

Signature of physician  
The State of Maryland

Signature of physician

BUREAU V. S.

JUN 13 1956

RECEIVED

Received from Bureau of Vital Statistics  
June 13, 1956



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06229

6226

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>24</u> TOWN <u>HARRE DE GRACE</u>		LENGTH OF STAY (in this place) <u>6 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>71</u> TOWN <u>Fallston</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL HOSP.</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) <u>ALBERT</u> (Middle) <u>HUGHES</u> (Last) <u>HUGHES</u>			4. DATE OF DEATH (Month) <u>JUNE</u> (Day) <u>27</u> (Year) <u>19 56</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Aug 2 1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>25</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GRANVILLE Z</u>			14. MOTHER'S MAIDEN NAME <u>HUGHES</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go, or unk.) <u>No</u> (If Yes, give war or dates of service) <u></u>		
16. SOCIAL SECURITY NO. <u></u>			17. INFORMANT & ADDRESS <u>Edith M. Hughes</u> <u>Fallston md</u>				
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>422.1</u> <u>Respiratory Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u></u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral accident</u>				instant			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic cardiovascular disease</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Sigmoid volvulus &amp; obstruction</u>				1 month			
19a. DATE OF OPERATION <u>6-20-56</u>		19b. MAJOR FINDINGS OF OPERATION <u>Sigmoid volvulus</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <u></u> <u></u> <u></u> <u></u> <u></u> <u></u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-21</u> , 19 <u>56</u> , to <u>6-27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6-27</u> , 19 <u>56</u> , and that death occurred at <u>10:10</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>James W. C. Finney</u>				ADDRESS (Street, city, town, state) <u>3301 Union Ave. Harre de Grace md</u>		DATE SIGNED <u>6-28-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/30/56</u>		NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		LOCATION (City, town, or county) (State) <u>Monkton md</u>	
24. REC'D BY REGISTRAR <u>June 29-56</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Rutz</u>		ADDRESS <u>Jarrettsville md</u>	



6227

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>6 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Winchester Johnson</u>		4. DATE OF DEATH Month Day Year <u>JUNE 7 1956</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 3, 1871</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MAIL CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PENN. R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WM. JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH (JOHNSON) GAMBRILL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT <u>MRS. ANNIE CAPT. JOHNSON</u>		Address <u>HAVER DE GRACE, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Insufficiency</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-3</u> , 19 <u>47</u> , to <u>6-7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6-7</u> , 19 <u>56</u> , and that death occurred at <u>12:40 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. L. Lewis M.D.</u>		DATE SIGNED <u>June 11-56</u>	
PHYSICIAN'S NAME (Type) <u>A. L. Lewis M.D.</u>		<u>HAVER DE GRACE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 11, 56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>HAVER DE GRACE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>HAVER DE GRACE, MD.</u>	
24a. REC'D BY REGISTRAR <u>June 11-56</u>		24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2531 61 NAF

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6228

## CERTIFICATE OF DEATH

06231

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>			
c. LENGTH OF STAY IN 1b <u>9 DAYS</u>				d. STREET ADDRESS <u>R D # 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JENNIE</u> Middle <u>ELIZABETH</u> Last <u>KINCAID</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>21</u> Year <u>1956</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 13 - 1878</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mrs. Morris G.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES H. KINCAID</u>			14. MOTHER'S MAIDEN NAME <u>JARAH KNIGHT</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>M. L. Bell</u> Address <u>R. near Hancock St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Insufficiency</u> <u>290.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pernicious Anemia</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 7</u> , 19 <u>56</u> , to <u>June 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 20</u> , 19 <u>56</u> , and that death occurred at <u>6:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>HAURE DE GRACE - MD.</u>				DATE SIGNED <u>HAURE DE GRACE - MD. 6-22-56</u>			
PHYSICIAN'S NAME (Type) <u>A. L. Lewis M.D.</u>				<u>HAURE DE GRACE - MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6/24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Run</u>		22d. LOCATION (City, town, or county) (State) <u>Rock Run, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>W. Hancock St., Md.</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>June 25, 56</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED  
JUN 25 1956  
BUREAU Y. F.

6229

## CERTIFICATE OF DEATH

06232

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LEONARD</u> Middle <u>KNAPP</u> Last <u>SR.</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 24-1889</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumbing Contractor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>LEONARD KNAPP</u>				14. MOTHER'S MAIDEN NAME <u>MARY ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Mrs. Mary Jane W. Knapp</u>				Address <u>Haver de Grace, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>June 30</u> , 19 <u>56</u> , to <u>June 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 30</u> , 19 <u>56</u> , and that death occurred at <u>10:55</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irvin H. Wachsmann</u>				ADDRESS (Street, city or town, state) <u>Haver de Grace</u>			
PHYSICIAN'S NAME (Type) <u>Irvin H. Wachsmann</u>				DATE SIGNED <u>7/3/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7/3/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Haver de Grace, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin H. Haver de Grace, Md.</u>				24a. RECEIVED BY REGISTRAR <u>G. L. Lewis</u>		24b. REGISTRAR'S SIGNATURE <u>DATE July 3-56</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH JUL 5 1956	
NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]	
AGE [Faint handwritten age]		RACE [Faint handwritten race]	
PLACE OF BIRTH [Faint handwritten place]		PLACE OF DEATH [Faint handwritten place]	
OCCUPATION [Faint handwritten occupation]		CAUSE OF DEATH [Faint handwritten cause]	
MANNER OF DEATH [Faint handwritten manner]		SIGNATURE OF PHYSICIAN [Faint handwritten signature]	
SIGNATURE OF REGISTRAR [Faint handwritten signature]		SIGNATURE OF WITNESS [Faint handwritten signature]	
DATE OF REGISTRATION JUL 5 1956		TIME OF REGISTRATION [Faint handwritten time]	

BUREAU V. 3

JUL 5 1956

RECEIVED

6251

CERTIFICATE OF DEATH

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Hartford</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Madonna - Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Madonna - Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>LEMMON ROAD</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>CLEVELAND</u> First <u>H.</u> Middle <u>LEMMON</u> Last		<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>24</u> Year <u>1956</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>DEC. 24-84</u>
<b>9. AGE</b> (In years last birthday) <u>71</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>6</u> Days <u>22</u>	<b>IF UNDER 24 HRS.</b> Hours <u>—</u> Min. <u>—</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farming</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farming</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>MADONNA MD</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>GEORGE-LEMMON</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY JANE KING</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>—</u>	
<b>17. INFORMANT</b> Address <u>Rockville MD</u> <u>Gda L. Lemmon</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u> (b) <u>Arteriosclerotic Hypertensive Heart Disease</u> (c) <u>Cerebral Accident</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 minutes</u> <u>15 Years</u> <u>1 hour</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>	
<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify</b> that I attended the deceased from <u>July 5, 1948</u> , to <u>June 22, 1956</u> , that I last saw the deceased alive on <u>June 22, 1956</u> , and that death occurred at <u>12:10 PM</u> , from the causes and on the date stated above.	
<b>ACTUAL SIGNATURE</b> <u>S. James Thomson Jr.</u>		<b>ADDRESS</b> (Street, city or town, state) <u>Jarrettsville, Md.</u>	
<b>PHYSICIAN'S NAME (Type)</b> <u>S. James Thomson Jr.</u>		<b>DATE SIGNED</b> <u>6/26/56</u>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>6/26-56</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Bethel</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Madonna Md</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Walter R. King Jarrettsville</u>		<b>24a. REC'D BY REGISTRAR</b> <u>6-28-56</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Prueella Lowndes</u>			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

BUREAU V. H.

JUL 2 1956

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to the interment, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06234

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Doa Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Everett</u> Middle <u>Love</u> Last <u>Love</u>		4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/13/1916</u>
9. AGE (In years last birthday) <u>30</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Team Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self.</u>	11. BIRTHPLACE (State or foreign country) <u>Madison, Tenn.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Dona Love</u>	
14. MOTHER'S MAIDEN NAME <u>Lona Bumgardner</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mr. Eula D. Love, 109 Wilson Road, Harford</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>G.S.W. Left Chest</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c) <u>  </u> DUE TO (a), stating the underlying cause last. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>		20c. TIME OF INJURY Month, Day, Year <u>6/14/56</u> Hour <u>8:20</u> p. m. <u>  </u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Harford Md.</u>	
20f. (City or town) <u>Harford</u> (County) <u>Harford</u> (State) <u>MD</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6/15/56</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE OF BURIAL <u>6/15/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>		22d. LOCATION (City, town, or county) <u>Mountain City Tenn</u> (State) <u>Tenn</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Hume, Harford, Md.</u> ADDRESS <u>  </u>		24a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>  </u>	

ACA

109 Wilson

3/13/1916 80

W. A.

Wife, John

Self

John (John) Jones

John (John) Jones, 109 Wilson Street, Baltimore, Md.

Unknown

W. A. 2

BUREAU V. S.

JUN 18 1956

RECEIVED

Received 6/18/56  
Baltimore, Md.

6231

## CERTIFICATE OF DEATH

06235  
Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>6 DAYS</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				24			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u>				d. STREET ADDRESS <u>839 Ontario</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE FLORENCE McEWING</u>				4. DATE OF DEATH Month Day Year <u>JUNE 12 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 18 1885</u>	
9. AGE (In years last birthday) yrs. <u>70</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hsmt.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Arthur Fulton</u>				14. MOTHER'S MAIDEN NAME <u>Flerage Angeline Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>James M. McEwing &amp; Haure de Grace</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>592X</u> DUE TO <u>Chronic Diffuse nephritis</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4-9</u> , 19 <u>56</u> , to <u>6-11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 11</u> , 19 <u>56</u> , and that death occurred at <u>4:43</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. L. Lewis</u>				ADDRESS (Street, city or town, state) <u>Haure de Grace Md</u>			
DATE SIGNED <u>6-14-56</u>							
PHYSICIAN'S NAME (Type) <u>A. L. Lewis</u>				HAURE DE GRACE MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>JUNE 14, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL</u>	
22d. LOCATION (City, town, or county) (State) <u>HAURE DE GRACE, MD.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>				ADDRESS <u>Haure de Grace Md.</u>		24a. REC'D BY REGISTRAR <u>June 14-1956</u>	
24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis MD.</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		MALE		45		JAN 15 1886		NEW YORK	
MARRIAGE		DATE		PLACE		NAME		DATE	
MARRIED		JAN 15 1900		NEW YORK		JAMES J. JONES		JAN 15 1900	
OCCUPATION		DATE		PLACE		NAME		DATE	
FARMER		JAN 15 1900		NEW YORK		JAMES J. JONES		JAN 15 1900	
CAUSE OF DEATH		DATE		PLACE		NAME		DATE	
HEART DISEASE		JAN 15 1931		NEW YORK		JAMES J. JONES		JAN 15 1931	
MANNER OF DEATH		DATE		PLACE		NAME		DATE	
NATURAL		JAN 15 1931		NEW YORK		JAMES J. JONES		JAN 15 1931	
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME		DATE	
JAMES J. JONES		JAN 15 1931		NEW YORK		JAMES J. JONES		JAN 15 1931	
SIGNATURE OF REGISTRAR		DATE		PLACE		NAME		DATE	
JAMES J. JONES		JAN 15 1931		NEW YORK		JAMES J. JONES		JAN 15 1931	

BUREAU V. 5

JUN 15 1931

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6232

## CERTIFICATE OF DEATH

06236

Reg. Dist. No.

185-

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>244 Haure de Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Minutes Aberdeen</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>71 Harford Memorial</u>				d. STREET ADDRESS <u>618 Belair Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Bertha</u> First <u>Baker</u> Middle <u>Middletown</u> Last				4. DATE OF DEATH <u>June 20</u> 19 <u>56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 11-1881</u> 75 yrs.	
9. AGE (In years lost birthday) <u>75</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
13. FATHER'S NAME <u>James B Baker</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Richardson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>J. S. Middleton - 618 Belair Ave Aberdeen</u> Address <u>res.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), or (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Acute Pulmonary Edema</u> DUE TO <u>Left ventricular failure</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <u>Hypertensive &amp; Arteriosclerotic Heart Dis.</u> DUE TO (c) <u>5 yr.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr.</u> <u>1 1/2 hr.</u> <u>5 yr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>56</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1947</u> , to <u>6-20-1956</u> , that I last saw the deceased alive on <u>6-20-1956</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Peter P. Rodman</u> M.D.				ADDRESS (Street, city or town, state) <u>8 Law St., Aberdeen, Md.</u> DATE SIGNED <u>6/21/56</u>			
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6/22/56</u>		<u>Bakers Cemetery</u>		<u>Aberdeen</u> <u>res.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Harney</u> ADDRESS <u>Aberdeen res.</u>				24a. REC'D BY REGISTRAR <u>June 22-56</u>		24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>	



CERTIFICATE OF DEATH

6583

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
JAMES B. GILLES		Male		45		JAN 15 1880		BALTIMORE, MD.		Carpenter	
RESIDENCE		MARRIAGE		CAUSE OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH		DATE OF DEATH	
1234 E. BALTIMORE ST.		Married		Heart Disease		2 Weeks		Home		JUN 10 1925	
FATHER		MOTHER		SIGNED BY		DATE		PLACE		TIME	
JAMES B. GILLES		JANE B. GILLES		J. B. GILLES		JUN 10 1925		BALTIMORE, MD.		10:00 AM	
TESTED BY		SIGNED BY		DATE		PLACE		TIME		REMARKS	
J. B. GILLES		J. B. GILLES		JUN 10 1925		BALTIMORE, MD.		10:00 AM		No further remarks.	

BUREAU V. S.

JUN 23 1925

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06237

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <b>Harford Co.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CORNELIUS PITTS</b>		4. DATE OF DEATH Month Day Year <b>June 18, 1956 19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/26/1889</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boiler Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt. Appraiser</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Albert Pitts</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Stansbury</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>War I. 218-10-0052</b>	
17. INFORMANT # Address <b>John Pitts Box 43 Laurel de Grace #1-rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Found Drowned</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>929.9</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Aberdeen, Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE <b>Paul F. Merri</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <b>6-18-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/21/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>W.T. Cahary Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Aberdeen Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John E. Varriing</b>		ADDRESS <b>aberdenn rd.</b>	
24a. REC'D BY REGISTRAR <b>June 21-56</b>		24b. REGISTRAR'S SIGNATURE <b>Nellie G. Perry</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is partially filled out with handwritten information.

BUREAU V. L.

JUN 25 1956

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy must be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06238

6233

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Harre de Grace</u>		LENGTH OF STAY (in this place) <u>36 hr</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Conowingo</u>		<u>07X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hosp-</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Ethel</u> (First) <u>May</u> (Middle) <u>Rambo</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>6</u> (Day) <u>24</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>WIDOWED</u>	<b>8. DATE OF BIRTH</b> <u>12/2/1892</u>	<b>9. AGE last birthday</b> <u>64</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Charlestown, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Levi Leelan</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Carrie</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>William Rambo, Conowingo Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>322.1 IMMEDIATE CAUSE (A)</b> <u>Cardiac Decompensation</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 days</u>			
<b>ANTECEDENT CAUSE(S) DUE TO</b> <u>Uremia</u>				<u>3 wks.</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> <u>Chronic alcoholism</u>				<u>2 years</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>none</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>6/2</u>, 19<u>56</u>, to <u>6/24</u>, 19<u>56</u>, that I last saw the deceased alive on <u>June 24</u>, 19<u>56</u>, and that death occurred at <u>1:45</u> P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Neil Taylor</u> M.D.				<b>DATE SIGNED</b> <u>6/24/56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>				<b>DATE THEREOF</b> <u>6/15/56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Conowingo Church Cem.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>June 27-56</u>				<b>REGISTRAR'S SIGNATURE</b> <u>G. L. Lewis M.D.</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Ralph M. Reed</u>	
<b>DATE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>ADDRESS</b>	
				<u>Conowingo Md</u>		<u>Conowingo Md</u>	

A34  
AP

# CERTIFICATE OF DEATH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

ALBANY

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06239

6234

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A155 1-55 10M

1. PLACE OF DEATH COUNTY <u>HARFORD</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BEL AIR</u> LENGTH OF STAY (in this place) <u>4 yrs.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>22 N. Atwood Rd</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BEL AIR</u> STREET ADDRESS (If rural give location) <u>22 N. Atwood Rd.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>EMMA</u> <u>(M.M.I.)</u> <u>RILEY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 21</u> 19 <u>56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>APRIL 11, 1878</u>		9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL BECKLEY</u>				14. MOTHER'S MAIDEN NAME <u>MARY HERSHEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Mrs. Ethel Ritchie</u> <u>22 N. Atwood Rd. Bel Air, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1</u> IMMEDIATE CAUSE (A) <u>Acute MYOCARDIAL INFARCTION</u>						<u>1 hr.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary thrombosis</u>						<u>Probably several hours</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>ARTERIOSCLEROTIC Cardiovascular disease</u>						<u>20+ yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>DIABETES MELLITUS</u>						<u>6 yrs.</u>	
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 21</u> , 19 <u>56</u> , to <u>June 21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 21</u> , 19 <u>56</u> , and that death occurred at <u>9:55</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Paul S. Stoner</u>				ADDRESS (Street, city, town, state) <u>M.D. 115 FULFORD AVE. BEL AIR, Md.</u>		DATE SIGNED <u>6/21/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>June 25/56</u>		NAME OF CEMETERY OR CREMATORY <u>St John's</u>		LOCATION (City, town, of county) (State) <u>Long Green Baltimore Md</u>	
24. REC'D BY REGISTRAR <u>6-24-56</u>		REGISTRAR'S SIGNATURE <u>Purilla Foxworth</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster Bel Air Md</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

BUREAU V. 2

JUN 28 1956

RECEIVED

PROSECUTION

DATE OF DEATH

6235

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE de GRACE</b>		c. LENGTH OF STAY IN 1b <b>3 hrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD Memorial Hosp.</b>		d. STREET ADDRESS <b>Monkton</b>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Robinson</b> Last <b>Robinson</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>10</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/17/29</b>
9. AGE (In years last birthday) <b>27</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Glenn JACKSON</b>		14. MOTHER'S MAIDEN NAME <b>Not Known</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Richard Robinson - Monkton, MD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Decompensation</b> <b>688.2</b> DUE TO <b>cause undetermined</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pregnancy - Term</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 10, 1956</b> , to <b>June 10, 1956</b> , that I last saw the deceased alive on <b>2:50 PM, 1956</b> , and that death occurred at <b>2:50 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F. J. Hatem</b>		ADDRESS (Street, city or town, state) <b>1771 Phila. Blvd, Aberdeen, Md.</b> DATE SIGNED <b>6/14/56</b>	
PHYSICIAN'S NAME (Type) <b>F. J. Hatem</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>6/14/56</b>	22b. DATE THEREOF <b>6/14/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MT. ZION</b>	22d. LOCATION (City, town, or county) (State) <b>LONG GREEN, MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. I. CHATMAN</b> ADDRESS <b>1701 Mt. Calvert St. - Baltimore, MD.</b>		24a. REC'D BY REGISTRAR <b>DATE 6-13-56</b>	24b. REGISTRAR'S SIGNATURE <b>Dr. A. J. Lewis</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>Hubbard</i>		AGE <i>65</i>		SEX <i>M</i>		RACE <i>W</i>		DATE OF DEATH <i>Aug 13 1955</i>	
PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>		STATE <i>Md</i>		ZIP CODE <i>21034</i>	
OCCUPATION <i>Retired</i>		EDUCATION <i>High School</i>		RELIGION <i>Methodist</i>		MARRIAGE <i>Married</i>		MANNER OF DEATH <i>Natural</i>	
CAUSE OF DEATH <i>Heart Disease</i>		IMMEDIATE CAUSE <i>Myocardial Infarction</i>		UNDERLYING CAUSE <i>Coronary Artery Disease</i>		PERIOD OF ILLNESS <i>2 weeks</i>		PLACE OF BIRTH <i>USA</i>	
DATE OF BIRTH <i>Aug 13 1955</i>		PLACE OF BIRTH <i>USA</i>		DATE OF DEATH <i>Aug 13 1955</i>		PLACE OF DEATH <i>Home</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>[Signature]</i>		SIGNATURE OF DECEASED <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>		SIGNATURE OF DECEASED <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>	
DATE OF DEATH <i>Aug 13 1955</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>		STATE <i>Md</i>	
ZIP CODE <i>21034</i>		MARRIAGE <i>Married</i>		RELIGION <i>Methodist</i>		EDUCATION <i>High School</i>		OCCUPATION <i>Retired</i>	
CAUSE OF DEATH <i>Heart Disease</i>		IMMEDIATE CAUSE <i>Myocardial Infarction</i>		UNDERLYING CAUSE <i>Coronary Artery Disease</i>		PERIOD OF ILLNESS <i>2 weeks</i>		PLACE OF BIRTH <i>USA</i>	
DATE OF BIRTH <i>Aug 13 1955</i>		PLACE OF BIRTH <i>USA</i>		DATE OF DEATH <i>Aug 13 1955</i>		PLACE OF DEATH <i>Home</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>[Signature]</i>		SIGNATURE OF DECEASED <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>		SIGNATURE OF DECEASED <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>	

RECEIVED  
JUN 13 1955  
BUREAU V. S.

## CERTIFICATE OF DEATH

Reg. Dist. No. 180

6253

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Ohio</b> b. COUNTY <b>Gurnsey</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b>				c. LENGTH OF STAY IN 1b <b>10 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>H.</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>19 56</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 9, 1879</b>		9. AGE (In years last birthday) yrs. <b>76</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Russell Thompson</b>				14. MOTHER'S MAIDEN NAME <b>Mahalie Artist</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Charles W. Smith, Cambridge Ohio</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>199.9</b> <b>INTESTINAL OBSTRUCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARCINOMA OF INTESTINAL TRACT</b> DUE TO (c) <b>GENERALIZED CARCINOMATOSIS, UNKNOWN</b> ORIGINAL SITE INTERVAL BETWEEN ONSET AND DEATH <b>8 MONTHS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>15 OCT 1955</b> , to <b>22 JUNE 1956</b> , that I last saw the deceased alive on <b>21 JUNE 1956</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles W. Stewart, Jr.</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>Box 95, Edgewood, Md. 6/24/56</b>			
PHYSICIAN'S NAME (Type) <b>CHARLES W. STEWART, Jr.,</b>				<b>EDGEWOOD, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June, 25, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Bel Air Harford Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. McCombs &amp; Son</b>				ADDRESS <b>Abingdon Md.</b>		24a. REC'D BY REGISTRAR <b>June 24, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Norma G. Moore</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. 3

JUN 26 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the State Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial or cremation.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06242

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6254 Item 9, Film G199 7-9-56 et

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Penn.</u> b. COUNTY <u>Chester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burlington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u> 75-x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>H</u> First <u>Stewart</u> Middle <u>Stewart</u> Last		4. DATE OF DEATH <u>June 17</u> 19 <u>56</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH	9. AGE (In years last birthday) <u>Approx. 45</u> yrs.
<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer, Paper Factory, Ash Co., N.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Riley Stewart</u>		14. MOTHER'S MAIDEN NAME <u>Ada May</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Sturdivant Funeral Home</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, Doro auto type</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>6</u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>U.S. 1</u>	20f. (City or town) <u>Darlington</u> (County) <u>Harford</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>June 18, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>West Jefferson</u>		22d. LOCATION (City, town, or county) <u>N.C.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H S Bailey</u> ADDRESS <u>Darlington</u>		24a. REC'D BY REGISTRAR <u>G. H. Kirk</u> DATE <u>June 17, 56</u>	
		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

MARY AND STATE DEPT. OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
JUL 2 1956  
BUREAU V. I.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy must be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6236

## CERTIFICATE OF DEATH

06243

Reg. Dist. No. 185-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		LENGTH OF STAY (in this place) <u>29 hrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>		<u>Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Watts</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>June 18 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>June 17, 1956</u>	9. AGE last birthday yrs. <u>1</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u>5</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>George Brooks Watts</u>				14. MOTHER'S MAIDEN NAME <u>Viola Beryl Coad</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
761.5 IMMEDIATE CAUSE (A) <u>Prematurity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>29 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>(Internal Premature Separation of Placenta)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>6:15</u> , 19 <u>56</u> , to <u>6:15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/18/56</u> , 19 <u>56</u> , and that death occurred at <u>9:30</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>G. H. Hatten</u>				ADDRESS (Street, city, town, state) <u>17 N. Phila Bldg. Baltimore Md.</u>			
DATE <u>6/18/56</u>				DATE SIGNED <u>6/18/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>6-18-56</u>		NAME OF CEMETERY OR CREMATORY <u>Harford Memorial Hospital</u>		LOCATION (City, town, or county) <u>Harford Md.</u>	
24. REC'D BY REGISTRAR <u>June 20-1956 G. L. Lewis M. A.</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. Tully</u>		ADDRESS <u>Administrator</u>	

2071223 X VO

# CERTIFICATE OF DEATH

BUREAU V. S.

JUN 21 1956

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy must be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6237

## CERTIFICATE OF DEATH

06244

Reg. Dist. No. 185-

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>HARFORD</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>HARFORD</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>HAURE DE GRACE</u>	<u>25 DAYS</u>	TOWN <u>ROCKS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>HARFORD MEMORIAL HOSP.</u>		<u>Sharon Rd.</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>LESTER</u> (Middle) <u>ELMER</u> (Last) <u>WAYNE</u>		(Month) <u>JUNE</u> (Day) <u>17</u> (Year) <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>8-15-1915</u>
9. AGE last birthday <u>40</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ERNE WAYNE</u>		14. MOTHER'S MAIDEN NAME <u>ROSIE WARD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
600.0 IMMEDIATE CAUSE (A) <u>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pyelonephritis Hemorrhagic</u>		<u>3 weeks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>cause undetermined</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pneumonia bilateral</u>		<u>3 weeks</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/23/56</u> , 19 <u>56</u> , to <u>8/17/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/17/56</u> , 19 <u>56</u> , and that death occurred at <u>10:53</u> M, from the causes and on the date stated above.			
SIGNATURE <u>William W. Ochsman</u>		DATE SIGNED <u>8/17/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR	
DATE THEREOF <u>6-20-56</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>	
NAME OF CEMETERY OR CREMATORY <u>Int. Cemetery</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Ochsman</u>	
LOCATION (City, town, or county) (State) <u>Fawn Stone, York Co. Pa.</u>		ADDRESS <u>Stewartstown Pa.</u>	

# CERTIFICATE OF DEATH

1956

Reg. No. 10

NAME OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF BURIAL

NAME OF CREMATION

NAME OF CREMATOR

NAME OF CREMATION

NAME OF CREMATOR

NAME OF CREMATION

NAME OF CREMATOR

NAME OF CREMATION

NAME OF CREMATOR

NAME OF CREMATION

NAME OF CREMATOR

NAME OF CREMATION

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NAME OF CREMATION

NAME OF CREMATOR

NAME OF CREMATION

NAME OF CREMATOR

BUREAU V. S.

JUN 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
 15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6238 CERTIFICATE OF DEATH

062435

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> <i>Maryland</i> <i>MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford Chase</i>	c. LENGTH OF STAY IN 1b <i>85 yrs.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford Chase</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>126 N. Union Ave.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Wilhelmina Taylor Weber</i>		4. DATE OF DEATH <i>6/11/56</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/28/1870</i>
9. AGE (In years last birthday) <i>86</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	11. BIRTHPLACE (State or foreign country) <i>Harford Chase</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>William Taylor</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mr. Henry Pilcher</i>		Address <i>Harford Chase, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>3-8</i> , 19 <i>49</i> , to <i>6-11</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>6-11-56</i> , 19 <i>56</i> , and that death occurred at <i>7:30 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. L. Lewis</i>		M.D. <i>Harford Chase, Md. 6-12-56</i>	
PHYSICIAN'S NAME (Type) <i>A. L. Lewis</i>		<i>Harford Chase - Md.</i>	
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)	22b. DATE THEREOF <i>6/13/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Harford Chase, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Conington &amp; Son, Harford Chase, Md.</i>		24a. REC'D BY REGISTRAR <i>June 12-56</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>A. L. Lewis M.D.</i>	

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